

STANDARD CERTIFICATE OF DEATH

State File No. **10440**BIRTH NO. **FILED MAR 19 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2266**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo. b. COUNTY 2259	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) 14 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Leonard b. (Middle) C. c. (Last) Snell		4. DATE OF DEATH (Month) (Day) (Year) March 10, 1954	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH Aug. 3, 1894
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HRS. Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Ashland, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Percy Snell		13b. MOTHER'S MAIDEN NAME Elizabeth Moyer	
14. NAME OF HUSBAND OR WIFE Lucille Snell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mr. Ray Wills		ADDRESS 1728 S. Vandeventer Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 4 days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES			
DUE TO (b) _____			
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gall Stones Biliary Cirrhosis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY; TOWN; OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 584x			
22. I hereby certify that I attended the deceased from Feb. 26, 1954 to Mar. 10, 1954 , that I last saw the deceased alive on Mar. 10, 1954 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE <i>Carl P. Donnelly, M.D.</i>		23b. ADDRESS Barnes Hospital	
23c. DATE SIGNED 3/10/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 13, 1954	
24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 11 1954		FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly, 3840 Lender Blvd.	
ADDRESS			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Francis Williamson

Licensed Embalmer No. 350

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.